Missouri Department of Social Services
Division of Aging

ABUSE, NEGLECT AND EXPLOITATION OF SENIORS AND ADULTS WITH DISABILITIES

Hotline: 1-800-392-0210

Annual Report
Fiscal Year 1999

Research and Evaluation
May 2000

Division of Aging

ABUSE, NEGLECT AND EXPLOITATION OF SENIORS AND ADULTS WITH DISABILITIES

Annual Report

Fiscal Year 1999

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Department of Social Services
Mission Statement

To maintain or improve the quality of life for the people of the state of Missouri by providing the best possible services to the public, with respect, responsiveness and accountability, which will enable individuals and families to better fulfill their potential.

Division of Aging
Mission Statement

To promote, maintain, improve, and protect the quality of life and the quality of care for Missouri's older adults and persons with disabilities so they may live as independently as possible with dignity and respect.

MEL CARNAHAN
GOVERNOR

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Dear Reader:

The Missouri Division of Aging is pleased to present the third *Elder Abuse, Neglect and Exploitation Annual Report*. Material in this report covers the activities during Fiscal Year 1999 (July 1, 1998 through June 30, 1999).

Information about Home and Community and Institutional Services programs is included in this report. We hope the data presented here will be useful to anyone interested in services provided by the Division of Aging to seniors, eligible adults between the ages of 18 and 59 who suffer from physical and mental impairments, and facility residents of Missouri in response to the problem of *elder abuse*.

Elder abuse is a widespread problem affecting hundreds of thousands of elderly people across the country. *Elder abuse* is, however, believed to be largely under-reported because of shame and the shroud of family secrecy. With some experts estimating as few as 1 out of 14 elder abuse incidents (excluding the incidents of self-neglect) coming to the attention of authorities, reports received by the Aging Hotline represent only a small portion of the problem.

Questions about the report should be directed to the Department of Social Services Research and Evaluation Unit at (573) 751-3060 or the Division of Aging at (573) 751-3082.

Sincerely,

Richard C. Dunn
Director

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Introduction

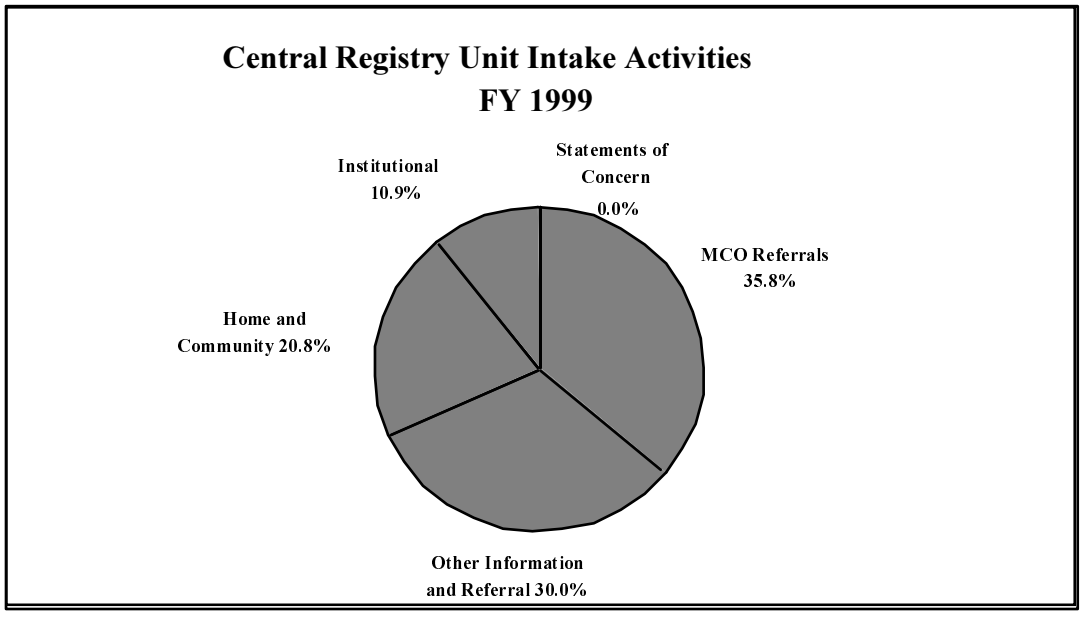
In October 1980, the Missouri Department of Social Services' Division of Aging established the Central Registry Unit (CRU) to screen and refer reports of abuse and neglect of elderly adults through a statewide hot line. In 1987, protective services were extended to disabled adults. The CRU currently handles calls regarding disabled and elder abuse, neglect and financial exploitation (A/N/E); regulation violations in institutional facilities licensed by the Division of Aging; screening referrals for Missouri Care Options (MCO); referrals to other agencies; and requests for information. The Division of Aging CRU abuse and neglect hotline operates year-round, 24 hours a day and may be reached at **1 (800) 392-0210**.

This report synthesizes data collected by the CRU on individual reports and completed investigations of A/N/E of elderly and disabled adults during fiscal year 1999.

Intake Activities

- During fiscal year 1999, the CRU received 67,914 calls, an increase of six percent from fiscal year 1998.

- Over one-third of the CRU intake activities were MCO referrals. Missouri Care Options (MCO) is a Division of Aging program that informs persons considering nursing facility care of available long-term care options. The CRU acts as a clearinghouse for receipt of MCO referrals. In fiscal year 1999, MCO referrals increased one percent to 24,287.



- The second largest number of calls received by the CRU, 30 percent, were for information requests and referrals to other agencies (Other I&R). This included referrals to Area Agency on Aging (AAA) offices; Alzheimer's information and support group referrals; heat crisis and cooling center information; Governor's Silver Club applications and information; Omnibus Budget Reconciliation Act (OBRA) pre-admission information requests; referrals to local Division of Aging Offices; and referrals to other agencies. During fiscal year 1999, the CRU received 22,120 information requests and referrals to other agencies, a 14 percent decrease from the previous year.

- Over 20 percent of hotline calls were reports of A/N/E in a home or community setting. In fiscal year 1999, CRU registered 14,099 hotline reports, an increase of five percent from fiscal year 1998.

- Reports of abuse/neglect in long-term care facilities or regulation violations in Division of Aging licensed facilities comprised nearly 11 percent of the total number of calls to the CRU. These reports increased 21 percent from fiscal year 1998.

- As of February 1998, policy revisions eliminated statements of concern incorporating these reports into other categories of reports. In fiscal year 1999, the CRU received nine facility self-reports. Facility self-reporting is a process established to allow facility representatives to self-report incidents occurring in the facility to the division. A self-report is not considered to be a complaint report. However, based upon information collected by CRU and investigative staff, a determination by division staff may be made to investigate and convert the incident into a complaint report if violations are determined to exist.

Investigations

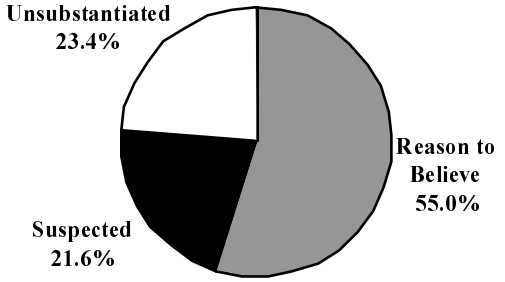
Upon report of an incident of A/N/E or a regulation violation, the CRU logs the information and forwards it to the Division of Aging field staff for investigation. After the investigation is complete, the investigator determines if A/N/E occurred or if the regulation violation was valid. The investigative findings are sent back to the CRU for entry into the Central Registry for Abuse, Neglect and Exploitation (CRANE) database. As applicable, results of investigations are referred to the appropriate law enforcement agencies and the Attorney General for their action.

It should be noted that the number of reports will differ from the number of investigations in any given fiscal year. "Report" refers to an allegation of A/N/E or regulation violation during the fiscal year. "Investigation" refers to a completed review of the report for which the findings were entered into the CRANE database. For example, a report could have been made in June and also investigated in June, but findings may not have been entered into the database until July. Therefore, the report will be counted in one fiscal year and the investigation will be counted in the following fiscal year.

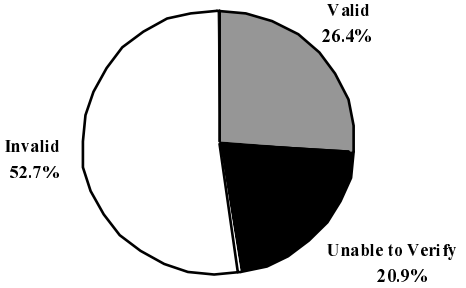
- The CRU received 12,467 completed investigations of home and community A/N/E in fiscal year 1999. Consistent with previous years, investigators found reason to believe that A/N/E occurred in 55 percent of these investigations, and suspected and unsubstantiated findings accounted for 22 percent and 24 percent, respectively of total investigations.

- The CRU received findings from 6,410 investigations of abuse/neglect and regulation violations in institutional settings. The majority of reports were found to be invalid. Twenty-one percent were not able to be verified (down from 25.3% in fiscal year 1998) while 27 percent were determined to be valid.

Home and Community Completed Investigations of Seniors and Adults with Disabilities Abuse, Neglect or Exploitation FY 1999



Institutional Completed Investigations of Seniors and Adults with Disabilities Abuse, Neglect or Exploitation FY 1999



Initial Reports

When a report is made to the Central Registry Unit (CRU) the intake social workers record the following information:

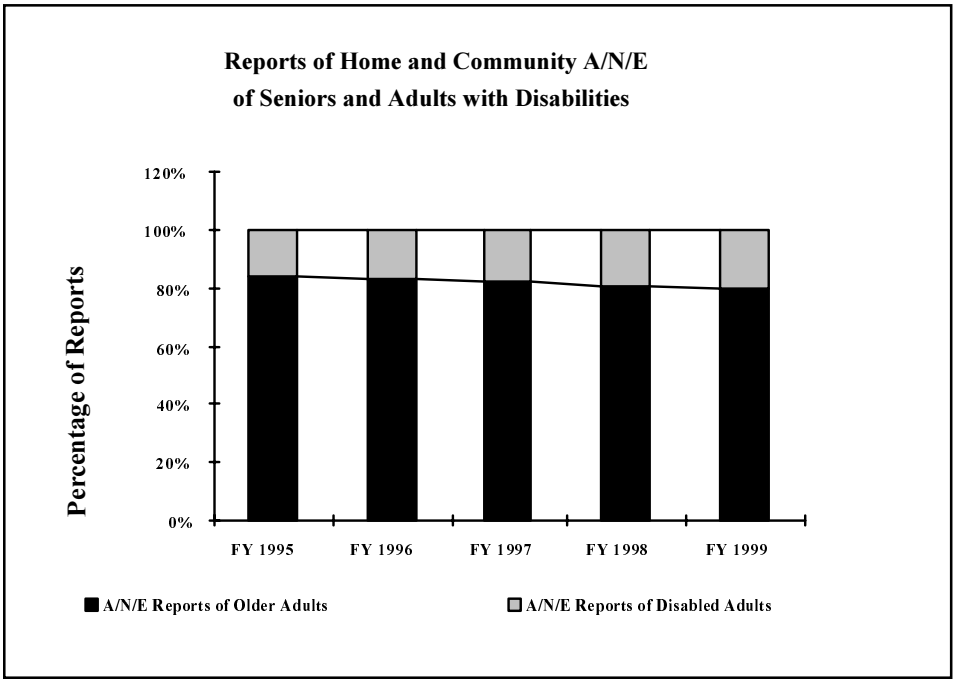
- the name, address and telephone number of the victim;
- the name, address and telephone number of the person responsible for the victim;
- the nature and extent of the victim's condition and the nature of A/N/E;
- the name of the reporter (which is held confidential); and
- the identity of the perpetrator (if applicable).

This information is forwarded to a county office for investigation. If the investigator discovers a crime occurred, the information may be referred to additional agencies for appropriate action.

Reports of Home and Community A/N/E of Seniors and Adults with Disabilities

	A/N/E of Older Adults	Annual Change	A/N/E of Disabled Adults	Annual Change	Total Reports	Annual Change
FY 1995	10,154	-4.9%	1,956	3.5%	12,110	-3.6%
FY 1996	9,916	-2.3%	2,060	5.3%	11,976	-1.1%
FY 1997	10,342	4.3%	2,281	10.7%	12,623	5.4%
FY 1998	10,833	4.7%	2,553	11.9%	13,386	6.0%
FY 1999	11,209	3.5%	2,890	13.2%	14,099	5.3%

Home and community A/N/E reports increased for the third year after previous declines. The majority of reports involve older adults though the number of reports concerning disabled adults has grown 48 percent since fiscal year 1995. The proportion of disabled adult A/N/E reports of total reports increased one percent in fiscal year 1999 continuing a five year trend.



Reporters

Missouri law mandates health care, social service, law enforcement and religious professionals who provide services to the elderly and disabled adults to report suspected A/N/E to the Department of Social Services. (For a complete list of mandated reporters see Appendix K, page 39.)

In fiscal year 1999, over half of the home and community A/N/E reports were from mandated reporters. Health care professionals, such as doctors, nurses, and hospital social service employees provided one-fourth of reports. The victim himself/herself reported A/N/E in nine percent of reports while relatives of the victims were the reporters 17 percent of the time. The proportion of reporters in fiscal year 1999 is consistent with prior years.

Reporters of Home and Community A/N/E of Seniors and Adults with Disabilities FY 1999

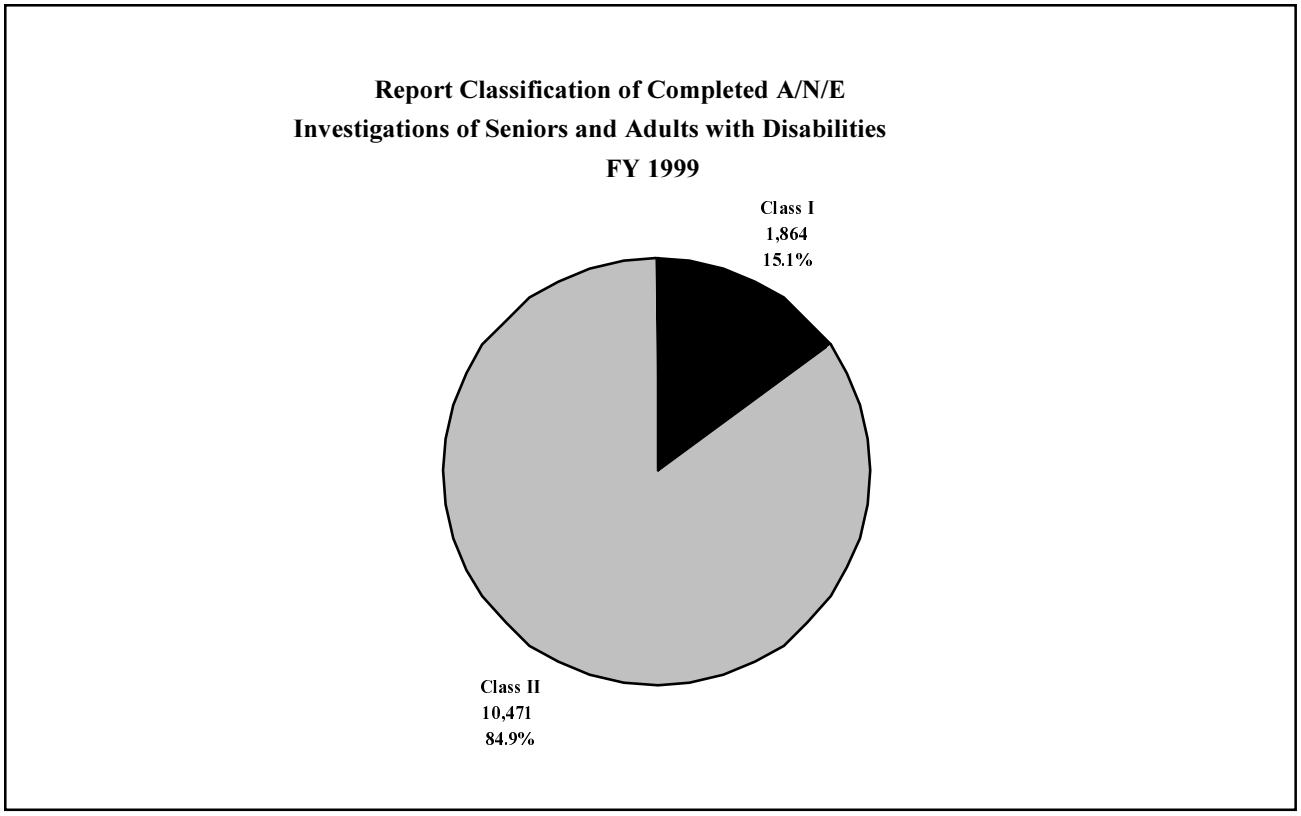
Reporter	Number of Reports	Percentage of Totals
Health Care Professional	**1888**	**14.1%**
Hospital Social Services Employee	1774	**13.3%**
Child/Spouse/Grandchild	**1471**	**11.0%**
Friend/Neighbor/Landlord	**1157**	**8.6%**
Anonymous/Unknown	**1215**	**9.1%**
Self	**1283**	**9.6%**
Other Relative	**956**	**7.1%**
In-Home Services Provider	**1192**	**8.9%**
DSS/Division of Aging Employee	**627**	**4.7%**
Long-term Care Employee	**614**	**4.6%**
Other	**1107**	**8.3%**
Law Enforcement	**594**	**4.4%**
Area Agency on Aging	**110**	**0.8%**
Government Official	**111**	**0.8%**
Total	**14,099**	**100.0%**

Note: Other includes Ombudsman, other residents, guardian, legal counsel and clergy.

Report Classification and Investigation Time Frames

In fiscal year 1999, the results of 12,467 completed investigations were entered into the Central Registry for Abuse, Neglect and Exploitation (CRANE) database. The report classification describes the severity of A/N/E and determines the time frame in which the investigator must conduct a face-to-face investigation. Class I reports involve life-threatening, imminent danger situations which indicate a high risk of injury or harm to an eligible adult. An investigator attempts to meet face-to-face with the victim of a Class I report within 24 hours. Class II reports involve non-threatening situations, which may result in harm or injury to an eligible adult. An investigation is attempted to be completed within seven days. Class III reports are non-protective services situations and do not always result in face-to-face contact.

Fiscal year 1999 Class I reports accounted for 15 percent and Class II for 85 percent of the total home and community A/N/E investigations. Class III or non-protective service investigative findings are not registered at CRU. The investigator met with the victim within 24 hours in 90 percent of the Class I investigations. For Class II investigations, 86 percent of the time investigators met with the victim within seven days of the report. Some reports may not have been investigated within the specified time frame because of not being able to locate the victims, the victims were uncooperative or they were moved to a protective environment.



Investigative Findings

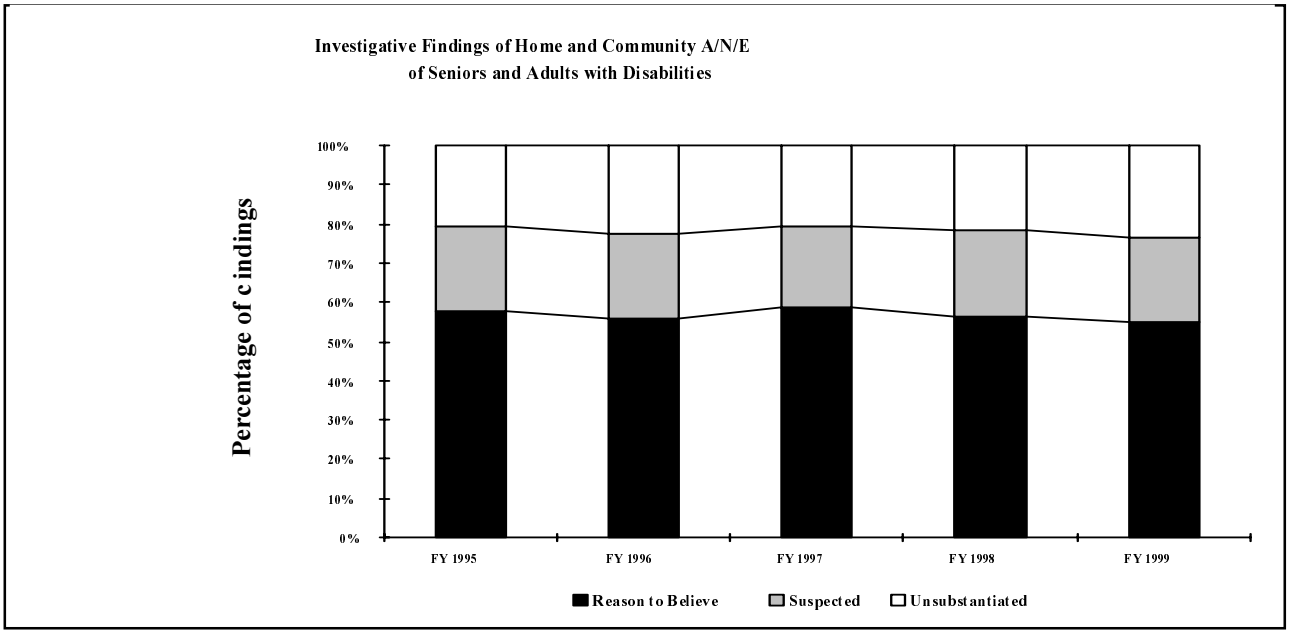
The investigators determine the factuality of the reports and classify their findings into the following categories: reason to believe, suspected and unsubstantiated. A reason to believe finding is returned when a substantial amount of evidence is found supporting the allegations contained in the reports. A/N/E is suspected when the reported allegations are probable or likely. A report is unsubstantiated when the evidence does not support the allegations in the report.

Completed investigations increased six percent in fiscal year 1999. Reason to believe findings increased three percent while suspected and unsubstantiated findings increased four percent and 15 percent, respectively.

Over half of the investigations completed in fiscal year 1999 were found reason to believe. Suspected and unsubstantiated findings accounted for 22 percent and 23 percent, respectively. The proportional findings of completed investigations have remained fairly stable over the past six years.

CRP pleted Investigative Findings Rf HRP e and CRP P unity
A/N/E Rf SeniRrs and Adults with Disabilities

	ReasRn tR Believe	Annual Change	Suspected	Annual Change	Unsub-stantiated	Annual Change	TRtal	Annual Change
FY 1995	6,347		2,375		2,297		11,019	
FY 1996	5,919	-6.7%	2,298	-3.2%	2,402	4.6%	10,619	-3.6%
FY 1997	6,432	8.7%	2,255	-1.9%	2,271	-5.5%	10,958	3.2%
FY 1998	6,630	3.1%	2,581	14.5%	2,550	12.3%	11,761	7.3%
FY 1999	6,851	3.3%	2,687	4.1%	2,929	14.9%	12,467	6.0%



Types of Abuse, Neglect and Exploitation

The types of A/N/E include various forms of physical abuse and neglect, medical neglect, verbal abuse, and financial neglect or exploitation. For analysis purposes, the various types of A/N/E allegations have been grouped into the following seven categories: physical abuse, physical neglect, emotional abuse, emotional neglect, financial exploitation, financial neglect and other. (See Appendix A, page 23, for definitions). There was an average of three different types of A/N/E allegations per completed investigation during fiscal year 1999.

Physical neglect had the greatest number of reported incidents (20,845); however, 44 percent of these reported incidents were unsubstantiated. Emotional neglect was the type of A/N/E with the greatest proportion (44 percent) of incidents determined as reason to believe. Upon investigation, financial exploitation was most frequently found to be unsubstantiated (61 percent). This is very likely the result of the lack of clear legal guidelines regarding the elements of financial exploitation and the criminal penalty.

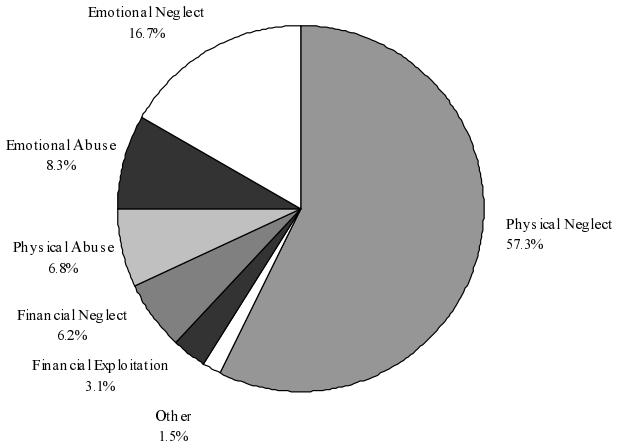
A/N/E of Seniors and Adults with Disabilities
FY 1999

		Findings		
Type of A/N/E	Number of Incidents	Reason to Believe	Suspected	Unsub-stantiated
Physical Neglect	20,845	36.0%	19.0%	44.0%
Emotional Neglect	5,055	44.0%	25.0%	31.0%
Emotional Abuse	3,260	34.0%	27.0%	40.0%
Physical Abuse	2,736	33.0%	21.0%	46.0%
Financial Neglect	2,317	35.0%	20.0%	44.0%
Financial Exploitation	2,504	16.0%	22.0%	61.0%
Other	453	44.0%	19.0%	36.0%

Note: The number of incidents is not directly related to the number of reports as victims may be subjected to multiple types of A/N/E.

National studies have found neglect as the most common form of senior citizen maltreatment in a home and community setting. Following the national trend, physical and emotional neglect were the most prevalent types of A/N/E found as reason to believe in Missouri. Abuse accounted for 15 percent, and financial exploitation or neglect for nine percent of reason to believe A/N/E findings.

Types of Home and Community A/N/E of Seniors and Adults with Disabilities Found Reason to Believe FY 1999



Resolutions and Services Provided

Upon conclusion of the investigation, the majority of cases found reason to believe resulted in the Division of Aging opening a case and providing protective services (27 percent) or the problem was resolved through a conclusive action or plan during the investigation (30 percent). Fourteen percent of the reported adults were placed in a long-term care facility or referred to another agency for help. (See table on page 10.)

Various services were provided to reported victims after investigation. In most cases, either the victim or his/her family was referred for counseling. Twenty-seven percent were authorized for an in-home service, such as personal care, home health or home delivered meals. Thirteen percent were provided legal or financial aid, including assignment of a guardian, a power of attorney or financial management. Almost 13 percent of reported victims were placed in a long-term care facility, mental health facility or an alcohol and/or drug program. (See table on page 10.)

Resolutions of Home and Community A/N/E of Seniors and Adults with Disabilities as Investigated FY 1999

Type of Service	Resolutions	Percentage
Conclusive Action or Plan	3,680	29.5%
Opened for Protective Services	3,376	27.1%
Substantiated, No Protective Services Needed	1,578	12.7%
Placed in Long-Term Care	1,242	10.0%
Refused Services	997	8.0%
Referred to Another Agency	547	4.4%
Client Died	479	3.8%
Client Moved	189	1.5%
Unable to Locate Client	135	1.1%
Other	244	2.0%
Total	12,467	100.0%

Services Provided to Reported Seniors and Adults with Disabilities Victims of Home and Community A/N/E FY 1999

Service	Number	Percent*
Counseling	11,705	93.9%
In-Home Services	3,372	27.0%
Legal/Financial	1,675	13.4%
Placement	1,564	12.5%
Emergency Assistance	875	7.0%
Other Assistance	1,008	8.1%
No Services Needed	459	3.7%

*More than one service may be provided after an investigation. Percent is the percent of 12,467 investigations.

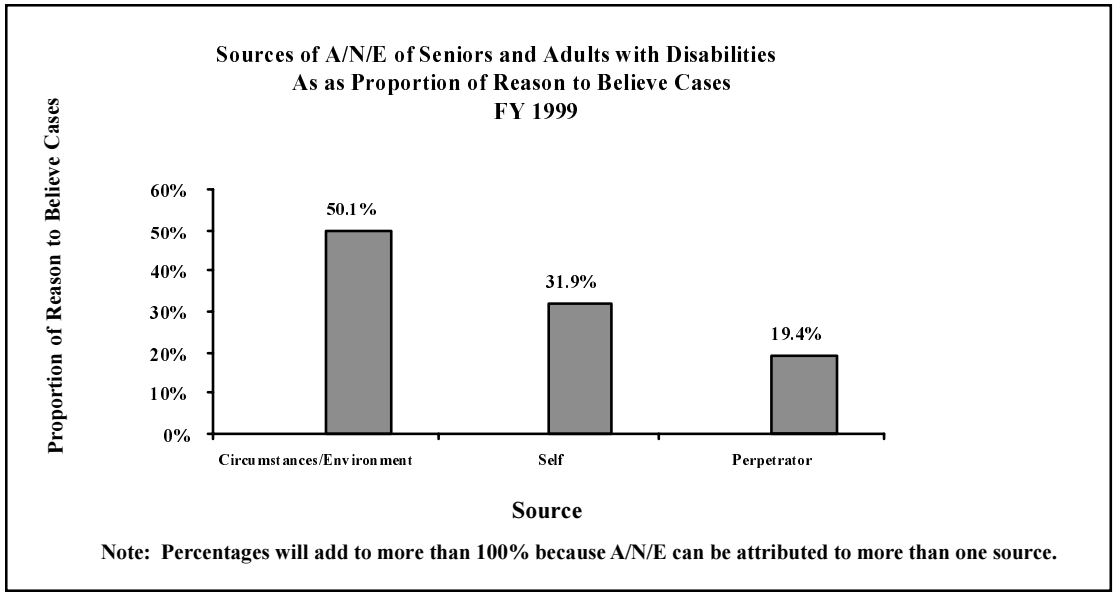
Source and Nature of A/N/E

In Missouri as well as nationally, the majority of perpetrators of seniors and adults with disabilities are family members of the victims. Causes identified by researchers that contribute to the occurrence of abuse include caregiver stress; impairment of the dependent adult; a cycle of violence where abusive behavior is the normal response to tension or conflict because other ways to respond have not been learned; and personal problems of abusers such as mental and emotional disorders, alcoholism, drug addiction and financial difficulty. Please see Appendix B (page 26) for a listing of the natures of abuse.

The source and nature of A/N/E were examined for reason to believe cases. Circumstances or environment were found to be the source of A/N/E in half of the reason to believe cases. The nature of abuse found in these cases included the victim being incapable of self-care (20%), confusion of the victim (8%) and inadequate physical care (8%). Conditions found in these living environments may include unclean or unsanitary shelter, spoiled food or physical fragility.

The reported adult was the source for nearly 32% of the cases found reason to believe. Self-abuse/neglect is characterized as the behavior of a person that threatens his/her own health or safety and generally manifests itself as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication and safety precautions.

Nineteen percent (19%) of the reason to believe cases were caused by a third party perpetrator. Seventeen percent (17%) of these reports were financial exploitation. Twelve percent (12%) of these reports were the result of physical abuse such as beatings, bruises, cuts, burns or bone fractures; sexual abuse; physical restraint; eviction from their home; or, medical or medication abuse.



Victim Demographics

For fiscal year 1999, the typical victim of A/N/E was a 70 year old, white female who lived alone. The age and race of victims were similar for all sources of A/N/E. The sex of the victims differed by source. Victims of perpetrators were more likely than the other sources of A/N/E to be female. While the majority of the victims of self-abuse/neglect and circumstances/environment lived alone, victims of perpetrators were more likely to live with a relative.

Victim Demographics of Seniors and Adults with Disabilities
Reason to Believe Cases by Source of A/N/E
FY 1999

	Self	Circumstances/ Environment	Perpetrator	All Victims
Age				
18-59 Disabled	**20.6%**	**19.3%**	**20.2%**	**22.0%**
60-84 Elderly	**60.0%**	**61.2%**	**61.3%**	**59.3%**
85+ Frail Elderly	**19.4%**	**19.5%**	**18.5%**	**18.8%**
Average Age	**70.7**	**71.2**	**69.7**	**69.9**
Race				
White	**78.0%**	**82.9%**	**77.6%**	**80.4%**
Black	**19.9%**	**14.8%**	**20.4%**	**17.3%**
Other	**2.1%**	**2.3%**	**2.0%**	**2.3%**
Sex				
Male	**37.8%**	**36.0%**	**30.4%**	**36.0%**
Female	**62.2%**	**64.0%**	**69.6%**	**64.0%**
Living Arrangements				
Living Alone	**53.1%**	**49.3%**	**30.9%**	**47.8%**
Living with Spouse	**15.9%**	**17.6%**	**18.4%**	**16.8%**
Living with Relative	**21.4%**	**23.9%**	**36.8%**	**24.9%**
Other	**9.6%**	**9.2%**	**13.9%**	**10.5%**

Perpetrator Demographics

An analysis of the demographic characteristics of perpetrators revealed that the typical perpetrator was white, younger than 50 years old, and related to the victim. Females were somewhat more likely than males to be perpetrators. This is partly attributable to the discrepancy between the sexes in our population and the prevalent sociological gender roles of females as the primary caregiver. Age was reported for 95 percent of perpetrators. In cases where age was reported, the majority of perpetrators were between the ages of 40 and 49 which differs from the age range for the majority of perpetrators in fiscal year 1998 (30-39 years).

Perpetrator Demographics of Reasonable Believe Cases
FY 1999

Age*		**Relationship to Victim**	
Less than 30	22.4%	Adult Child	32.0%
30-39	21.2%	Other Relative	23.6%
40-49	23.8%	Spouse	13.9%
50-59	11.1%	In-Home Service Provider	9.9%
60-69	6.1%	House/Private/Friend/Neighbor	8.7%
70-79	4.3%	Health Care Professional	2.6%
80+	11.0%	Other	9.3%
Average Age	45.7		
Race		**Living With Victim**	
White	64.2%	Yes	49.2%
Black	20.1%	No	50.8%
Other	0.6%		
Not Reported	15.1%		
Sex			
Male	45.8%		
Female	49.5%		
Not Reported	4.7%		

*** Age is based on the 95% of cases in which age was reported.**

Initial Reports

The report process for abuse or neglect (A/N) or regulation violations in a long-term care facility is similar to the process for home and community A/N/E. The CRU workers log the necessary information and then forward the complaints to one of seven regional offices for investigation.

In fiscal year 1999, the CRU logged 7,408 institutional related reports, an increase of 4.5 percent from fiscal year 1998. The number of A/N reports decreased for the third year to 683. Regulation violations increased nearly 25 percent from the previous year. Statements of concern were re-defined in 1998 and absorbed into other categories, therefore are no longer measured. A new category of self-reports was added this year. This category of reporting allows institutions to report violations occurring in their facility.

In fiscal year 1999, A/N reports accounted for nine percent of total institutional reports while regulation violations were 91 percent and self-reports were less than one percent of total institutional reports.

Initial Reports of Institutional Abuse, Neglect and Regulation Violations

Fiscal Year	Abuse/ Neglect	Regulation Violations	Statements of Concern	Self Reports	Total	Annual Change
FY 1995	656	6,400			7,056	
FY 1996	886	5,956	801		7,643	8.3%
FY 1997	832	4,759	1636		7,227	-5.4%
FY 1998	716	5,375	999		7,090	-1.9%
FY 1999	683	6,716		9	7,408	4.5%

Reporters

Employees of long-term care (LTC) facilities and health care professionals that have a reasonable cause to suspect A/N of a facility resident are mandated by law to report the incident to the CRU. (See Appendix K, page 39, for a complete list of mandated reporters.)

Fifty-seven percent of A/N reports originated from long-term care facility employees down from 64 percent last year. Directors of Nursing and administrators comprised 43 percent of the A/N calls. Regulation violations were most often reported by anonymous or unknown sources (25 percent) the resident's child (13 percent) and directors of nursing (11 percent).

Reporters of Institutional Abuse/Neglect and Regulation Violations
FY 1999

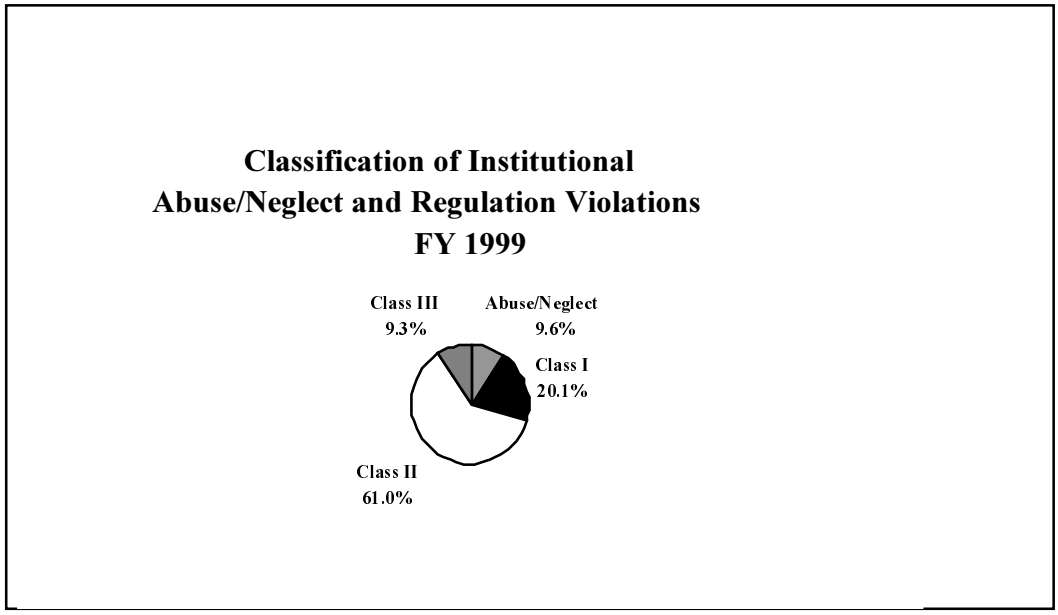
	Abuse/Neglect		Regulation Violations		Total	
	Number	Percent	Number	Percent	Number	Percent
Long-Term Care Employees	391	57.2%	2,048	30.5%	2,439	33.0%
Director of Nursing	161	23.6%	737	11.0%	898	12.1%
Administrator	130	19.0%	537	8.0%	667	9.0%
Other Employee	27	4.0%	192	2.9%	219	3.0%
LPN/RN	33	4.8%	219	3.3%	252	3.4%
Former Employee	12	1.8%	181	2.7%	193	2.6%
Nurse Aide	20	2.9%	131	2.0%	151	2.0%
Operator/Manager	8	1.2%	50	0.7%	58	0.8%
Instructor	0	0.0%	1	0.0%	1	0.0%
Relative	85	12.4%	1,663	24.8%	1,748	23.6%
Son/Daughter	48	7.0%	897	13.4%	945	12.8%
Other Relative	18	2.6%	270	4.0%	288	3.9%
Grandchild	2	0.3%	166	2.5%	168	2.3%
Sibling	10	1.5%	124	1.8%	134	1.8%
Spouse	4	0.6%	145	2.2%	149	2.0%
Parent	3	0.4%	61	0.9%	64	0.9%
Other	207	30.3%	3,005	44.7%	3,212	43.4%
Anonymous/Unknown	74	10.8%	1,659	24.7%	1,733	23.4%
Self	16	2.3%	441	6.6%	457	6.2%
Other*	25	3.7%	271	4.0%	296	4.0%
Friend/Neighbor	6	0.9%	163	2.4%	169	2.3%
Hospital Social Service Employee	36	5.3%	192	2.9%	228	3.1%
Health Care Professional	38	5.6%	157	2.3%	195	2.6%
DSS/Division of Aging Employee	12	1.8%	122	1.8%	134	1.8%
Total	683	100.0%	6,716	100.0%	7,399	100.0%

* Other includes government officials, law enforcement, other residents, guardians, Area Agency on Aging, clergy, ombudsman and others.

Report Classification and Investigation Time Frames

In fiscal year 1999, the results of 6,410 completed institutional investigations were entered into the Central Registry for Abuse, Neglect and Exploitation (CRANE) database. Reports were classified based on the severity of the A/N and/or regulation violation, which then determined the time frame in which the investigator was to conduct the investigation.

A/N and Class I reports accounted for almost one-third of the investigated reports. Because of the possibility of imminent danger to residents, 94 percent of these reports were investigated within 24 hours. Class II and III reports, which are not indicative of imminent danger to residents, accounted for the remaining 70 percent of reports. For Class II reports, 50 percent were investigated within 30 days, an increase of 22 percent from fiscal year 1998. Class III reports required an investigation at the next scheduled inspection or survey of the facility.



Investigative Findings of Abuse/Neglect Reports

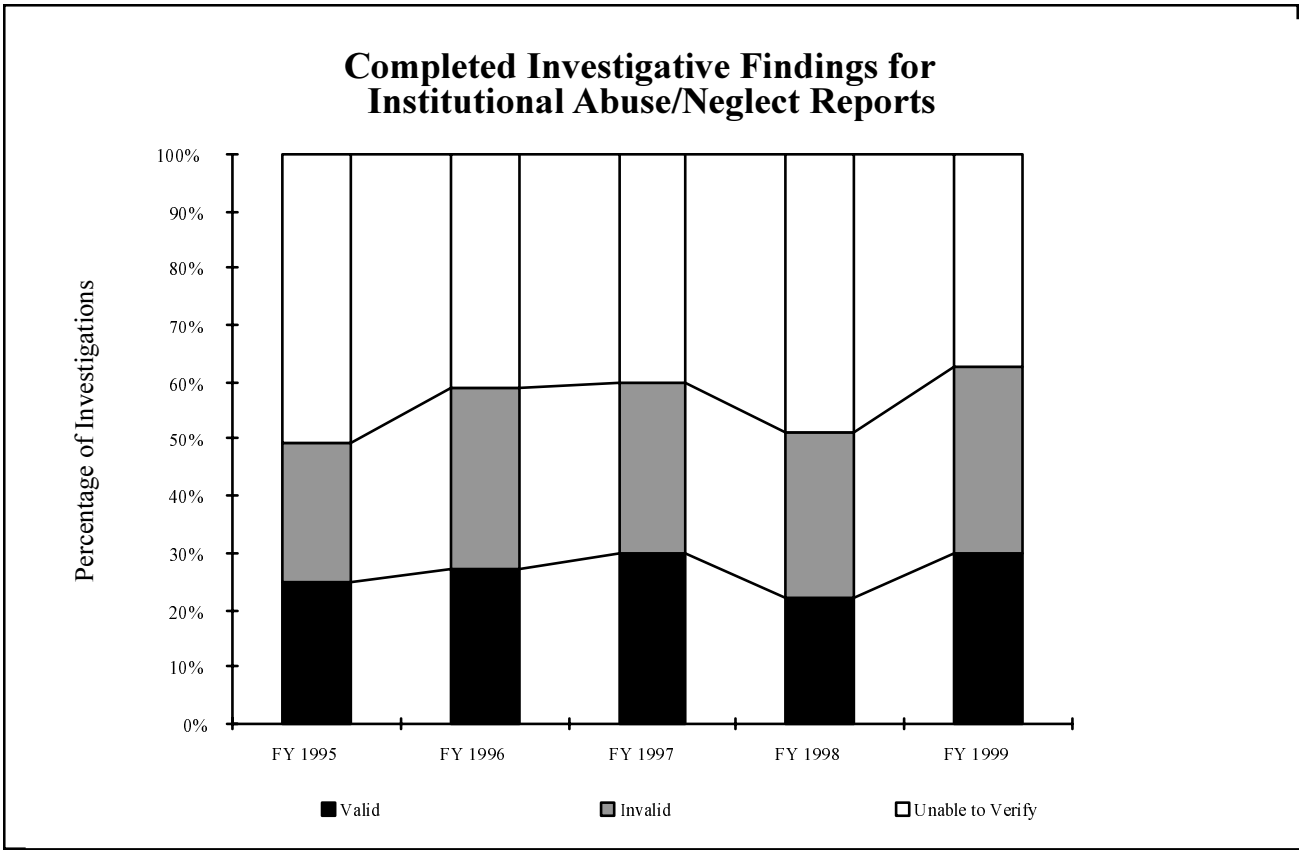
During investigations, division staff determine the factuality of the reports and classify their findings into the following categories: valid, invalid and unable to verify. A report is determined to be valid when investigators conclude the allegation did occur and/or there was a statutory violation. Invalid is returned when a conclusion is reached that the allegation did not occur, or that it occurred but it is not a statutory violation. Unable to verify is the result when there is conflicting information to the extent that no conclusion can be reached.

A total of 616 A/N investigations were completed in fiscal year 1999. Valid findings increased slightly while invalid findings remained constant. Unable to verify findings dropped to the lowest proportion in 6 years (37 percent).

Thirty-three percent were determined to be invalid. The percentage of valid findings returned was 30 percent in fiscal year 1999, an increase of 20 percent from fiscal year 1998.

Completed Investigative Findings of Institutional Abuse/Neglect Reports

Fiscal Year	Valid	Percent of Total	Annual Change	Invalid	Percent of Total	Annual Change	Unable to Verify	Percent of Total	Annual Change	Total	Annual Change
FY 1995	148			143			299			590	
FY 1996	237		60.1%	276		93.0%	355		18.7%	868	47.1%
FY 1997	256		8.0%	255		-7.6%	340		-4.2%	851	-2.0%
FY 1998	154	22.1%	-39.8%	202	28.9%	-20.8%	342	49.0%	0.6%	698	-18.0%
FY 1999	185	30.0%	20.1%	201	32.6%	-0.5%	230	37.3%	-32.7%	616	-11.7%

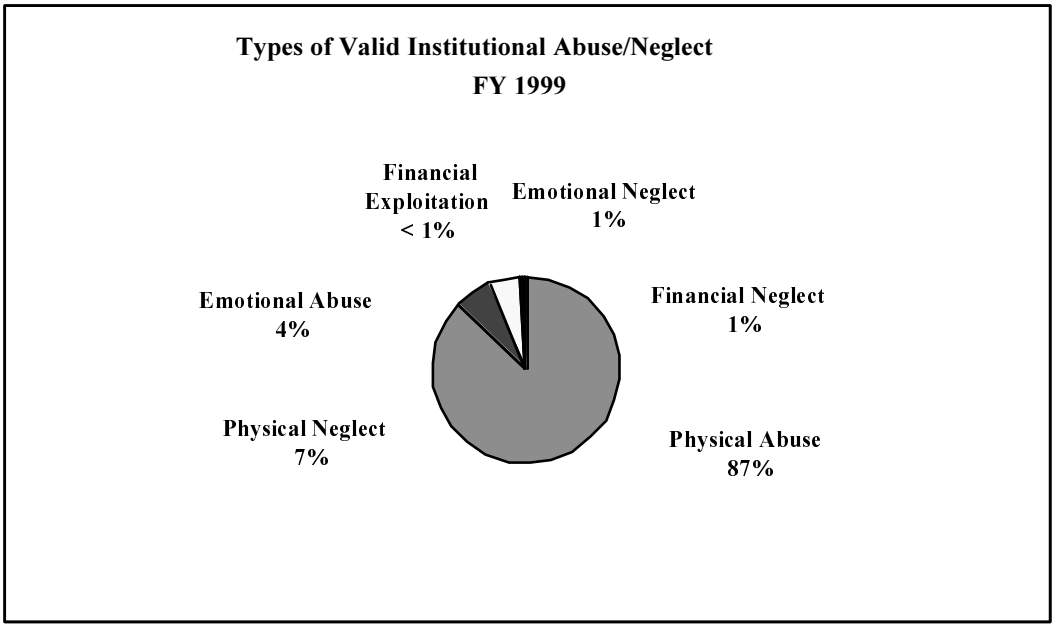


Types of Abuse/Neglect

Physical abuse was most often alleged in the institutional A/N reports but the allegations were most often found to be invalid or unverifiable. However, of valid findings, physical abuse was the highest reported type of A/N (87%). The majority of physical neglect allegations were found to be invalid while emotional abuse was most often unable to be verified.

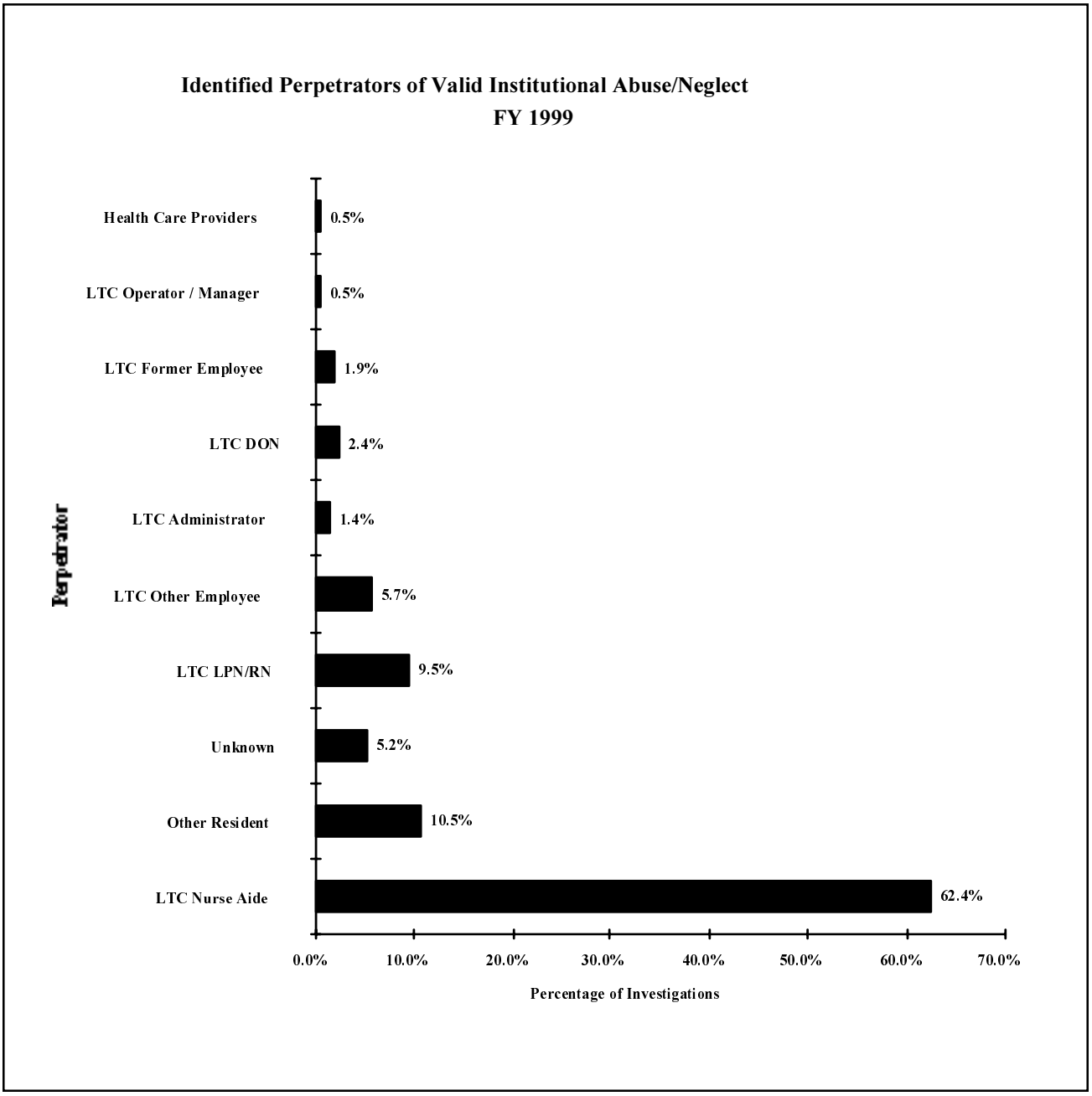
Types of Institutional Abuse/Neglect
FY 1999

Type of Abuse	Number of Allegations	Findings		
		Valid	Invalid	Unable to Verify
Physical Abuse	889	28.4%	35.9%	35.8%
Physical Neglect	86	30.8%	53.9%	15.4%
Emotional Abuse	54	20.4%	27.8%	51.9%
Emotional Neglect	3	66.7%	33.3%	0.0%
Financial Exploitation	6	16.7%	33.3%	50.0%
Financial Neglect	2	100.0%	0.0%	0.0%



Perpetrators of Valid Abuse/Neglect Investigations

During fiscal year 1999, the most frequently identified perpetrators of abuse/neglect in long-term care facilities were nurse aides (62 percent) an increase from 48 percent in fiscal year 1998. Other residents were the perpetrators of valid abuse/neglect in 11 percent of investigations, a decrease from 20 percent in fiscal year 1998.



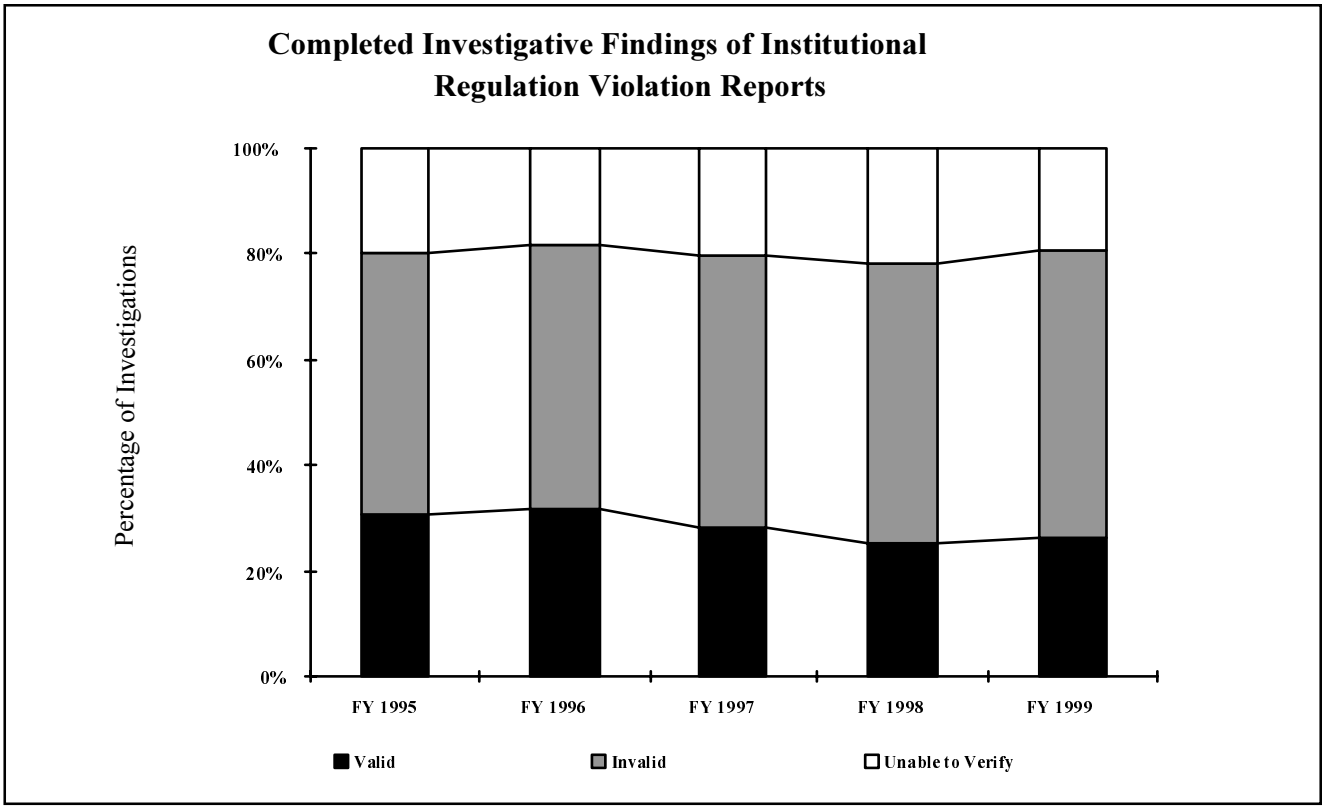
Investigative Findings of Regulation Violation Reports

In fiscal year 1999, 5,794 reports of regulation violations were investigated, a 22 percent increase from fiscal year 1998. All categories of findings increased this year with invalid findings increasing the most (27 percent) followed by valid findings (25 percent) and unable to verify findings (8 percent).

The proportion of invalid findings decreased slightly following an increase over the last five years. Valid findings accounted for 26 percent of all conclusions, slightly higher than in 1998 and counter to the previous five year decline. Unable to verify conclusions have remained fairly steady since fiscal year 1994.

Completed Investigative Findings of Institutional Regulation Violation Reports

Fiscal Year	Valid	Annual Change	Invalid	Annual Change	Unable to Verify	Annual Change	Total	Annual Change
1995	1,839		3,001		1,192		6,032	
1996	1,955	6.3%	3,096	3.2%	1,135	-4.8%	6,186	2.6%
1997	1,502	-23.2%	2,727	-11.9%	1,076	-5.2%	5,305	-14.2%
1998	1,205	-19.8%	2,501	-8.3%	1,032	-4.1%	4,738	-10.7%
1999	1,511	25.4%	3,174	26.9%	1,109	7.5%	5,794	22.3%



Types of Regulation Violations

Regulation violations regarding resident care and resident rights were the most frequent allegations in reports. Investigators determined that nearly 24% of the resident care and 12% of the resident rights allegations to be valid. As a percentage, violations most often found to be valid included fire safety and physical plant violations.

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) Y 1999

TySHs Rf RHguODtiRn 9 iRODtiRns	1 umEH- Rf AOOgDtiRns	) indings 9 DGd	InvDGd	8 nDEODtR 9 H-ify
RHsidHht CDrH	3,968	23.5%	58.2%	18.3%
1 ursing CDrH	859	19.6%	60.7%	19.8%
RHsidHht Rights	1,106	11.8%	67.1%	21.1%
3 HsRnnHO	636	17.5%	72.6%	9.9%
DiHDry	420	8.1%	81.0%	11.0%
SDnitDtiRn	362	15.8%	75.7%	8.6%
0 HlicDtiRns	363	15.2%	63.9%	20.9%
3 hysicDO3 ODnt	269	26.8%	65.4%	7.8%
3 HsRnDO) unds Dnd 3 rRSHty	222	18.0%	58.6%	23.4%
) irHSDfHy	77	37.7%	58.4%	3.9%
AdministrDtivH/ icHnsing	34	11.8%	76.5%	11.8%
SRciDODnd (mRtiRnDO1 HHls	52	9.6%	61.5%	28.9%
2 thH-	22	19.1%	23.8%	57.2%

Long-Term Care Ombudsman Program

The Missouri Long-Term Care Ombudsman Program advocates to protect the health, safety, welfare and rights of residents in long-term care facilities. An Ombudsman is a citizen volunteer who acts on the behalf of the resident to resolve problems, informs residents of their rights and provides information on resident needs to the community. While the Ombudsman program does not deal directly with abuse/neglect cases, it is felt that the presence of an ombudsman in a long-term care facility helps diffuse situations before they develop into abuse or neglect. Information concerning the Ombudsman program may be accessed by calling: **1 (800) 309-3282**.

During fiscal year 1999, ombudsmen handled 5,341complaints made by or on behalf of nursing home residents. The majority of the complaints concerned resident care and quality of life issues. The three most frequent complaints in nursing homes were care issues; resident rights of autonomy, choice, exercise of rights and privacy; and dietary.

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	1 umEHr Rf CRmSODints	3HrcHnt	1 umEHr Rf CRmSODints	3HrcHnt
QuDGty Rf / ifH	1,501	28.1%	102	23.6%
DiHDry	557	10.4%	34	7.9%
(nvirRnmHntDOCRnditiRns	612	11.5%	52	12.0%
ActivitiHs Dnd SRciDOSHrvicHs	332	6.2%	16	3.7%
RHsidHnt CDrH	1,559	29.2%	45	10.4%
CDrHIssuHs (SHrsRnDODssistDncHDnd hygiHnH)	1,266	23.7%	42	9.7%
RHnDEiGtDtiRn Rr 0 DintHnDncHRf) unctiRn	273	5.1%	3	0.7%
RHstrDints, ChHmicDODnd 3hysicDO	20	0.4%	0	0.0%
RHsidHnt Rights	1,481	27.7%	123	28.5%
AutRnRmy, ChRicH, (xHrcisHRf Rights, 3rivDcy	668	12.5%	19	4.4%
) inDnciDO,3rRSHrty (nRt finDnciDOHkSORtDtiRn)	340	6.4%	23	5.3%
AdmissiRn, TrDnsfHr, DischDrgH, (victiRn	193	3.6%	55	12.7%
AccHss tRInfRrmDtiRn	180	3.4%	15	3.5%
AEusH, GrRss 1 HgORct, (xSORtDtiRn	100	1.9%	11	2.5%
AdministrDtiRn	800	15.0%	162	37.5%
StDffing	464	8.7%	87	20.1%
SystHm/2 thHr	248	4.6%	60	13.9%
3RGtiHs, 3rRcHdurHs, AttitudHs, RHsRurcHs	40	0.7%	4	0.9%
StDtH0 HlicDid AgHncy	12	0.2%	3	0.7%
CHrtificDtiRn// icHnsing AgHncy	36	0.7%	8	1.9%
TRtDO	5,341	100.0%	432	100.0%

General Terms*

A/N/E: Abuse, neglect or exploitation.

A/N: Abuse or neglect.

Abuse: The infliction of physical, sexual or emotional injury or harm.

Neglect: The failure by the individual or by those responsible for the care, custody and control of the individual, to provide services which are reasonable and necessary to maintain the physical and mental health of the individual, when such failure presents either an imminent danger to the health, safety, or welfare of the individual or a substantial probability that death or serious physical harm would result.

Exploitation: Illegal or improper use of a person's property or resources to the degree that substantial risk or harm exists.

Eligible Adults: 1) Missouri residents who are aged 60 or older; 2) adults with physical or mental impairments that limit their ability to perform activities of daily living; and 3) residents of nursing facilities, residential care facilities, or ICF/MR facilities.

fnvestigator: Division of Aging worker that determines the validity of allegations contained in reports which allege abuse, neglect or exploitation of an eligible adult or a regulation violation in a facility licensed by the Division of Aging.

MCO Referral: Missouri Care Options. MCO referrals are initiated by calls from hospitals, nursing facilities or the community to the CRU. The CRU determines if the referred individual meets the definition of an MCO client (considering facility placement and potentially Medicaid eligible), completes the necessary paperwork, and forwards the referral to the appropriate Division of Aging field office for assessment and follow-up.

Regulation s iolation: Evidence of facility noncompliance with rules and regulations.

Statement of Concern: A complaint received about a facility, which is not within the regulatory jurisdiction of the Division of Aging or does not have any effect on resident care.

mrpetrator: An individual, other than the victim himself/herself or circumstances/environment, who committed the abuse.

*Terms as defined by Chapter 660.250 RSMo Protective Services for Adults.

Classes of Home and Community Reports

Class f: Imminent danger or an emergency situation.

Class ff: Direct or immediate relation to the health, safety or welfare of the reported adult, but which does not create imminent danger.

Description of Home and Community Investigative Findings

Reason to Believe: Substantial amount of evidence is found supporting the allegations contained in the report.

Suspected: Based on worker judgement, allegations contained in the report are probable or likely.

r nsubstantiated: The evidence of the investigation does not support the allegations in the report.

Classes of Institutional Reports

A/N: The infliction of physical, sexual or emotional injury or harm; or the failure to provide, by those responsible for the care, custody of a resident in a facility, the services which are reasonable and necessary to maintain the physical and mental health of the resident when such failure presents imminent danger or a substantial probability that death or serious physical harm would result.

Class f: A violation of regulations which would present either an imminent danger to the health, safety or welfare of any resident or a substantial probability that death or serious physical harm would result.

Class ff: Violations which have a direct or immediate relation to the health, safety or welfare of any resident, but which do not create an imminent danger.

Class fff: Violations, which have an indirect, or a potential impact on the health, safety or welfare of any resident.

Description of Institutional Investigative Findings

s alid: A conclusion the allegation did occur and there was a statutory violation; or a conclusion that there is a reasonable likelihood that the allegation did occur and there was a statutory or regulation violation.

r nable to s erify: There is conflicting information collected to the extent that no conclusion could be reached.

fnvalid: A conclusion that the allegation did not occur; a conclusion that there is not a reasonable likelihood that the allegation occurred; or a conclusion that the allegation either occurred, or there is a reasonable likelihood that it occurred, but there is not a statutory or regulatory violation.

Types of Abuse, Neglect and Exploitation

Emotional Abuse: Emotional/verbal abuse, harassment, and family discord.

Emotional Neglect: Emotionally disturbed, behavior problems, confused, depressed, suicidal, stressed.

Financial Exploitation: Illegal or improper use of a person's property or resources to the degree that substantial risk or harm exists.

Financial Neglect: Financial management needed, financially needy, legal need, guardian needed.

Physical Abuse: Beatings, bruises/welts, cuts/burns, bone fractures, sexual abuse, locked in/out of home, evicted, substance abuse.

mhysical Neglect: Self-care limitation, inadequate physical care, disregard for personal safety, isolation, inadequate utilities, poor nutrition, medical neglect, inadequate supervision, filth/vermin/squalor, placement needed, heavy care responsibility.

1 DturHRf AEusH

Beatings	Isolation	Emotionally Disturbed
Bruises/Welts	Inadequate Housing	Behavior Problems
Cuts/Wounds	Inadequate Utilities	Confused
Bone Fractures	Inadequate Food	Depressed
Sexual Abuse	Medical Neglect	Suicidal
Physical Restraint	Improper Supervision	Stressed
Locked In/Out Home	Filth/Squalor	Financial Exploitation
Eviction	Placement Needed	Financial Management Needed
Medical Abuse	Heavy Care Responsibility	Finances Needed
Substance Abuse	Emotional Abuse	Legal Need
Incapable Self Care	Verbal Abuse	Guardian Needed
Inadequate Physical Care	Harrassment	Other
Disregard Personal Safety	Family Discord	

Appendix C.
Missouri Division of Aging Contact Information

Missouri Division of Aging
Home and Community Service Regions

Regions 1 & 10
Division ofAging
149 Park Central Square
Springfield, MO 65806
417/895-6456

Region 2
Division ofAging
130 South Frederick
P.O. Box 189
Cape Girardeau, MO 63701
573/472-5233

Regions 3 & 7
Division of Aging
Suite 405, State Office Bldg.
615 East 13th St.
Kansas City, MO 64106
816/889-3100

Region 4
Division of Aging
525 Jules St., Room 319
St. Joseph, MO 64501
816/387-2100

Region 4
Division of Aging
525 Jules St., Room 319
St. Joseph, MO 64501
816/387-2100

Regions 5 & 6
Division of Aging
Parkade Center, #217
Columbia, MO 65203
573/882-9474

Regions 8 & 9
Division of Aging
Wainwright Bldg.
111 N. 7th St., 4th Floor
St. Louis, MO 63101
314/340-7300

Missouri Division of Aging
Institutional Service Regions

Region 1
Division of Aging
149 Park Central Square
Springfield, MO 65806
417/895-6435

Region 2
Division of Aging
P.O. Box 1207
Poplar Bluff, MO 63901
573/840-9580

Region 3
Division of Aging
4th Floor, State Office Bldg.
615 E. 13th St.
Kansas City, MO 64106
816/889-2818

Region 4
Division of Aging
1115 West Grand
P.O. Box 633
Cameron, MO 64429
816/632-6541

Region 5
Division of Aging
311 N. Rollins
Macon, MO 63552
660/385-5763

Region 6
Division of Aging
3418 Knipp Drive
P.O. Box 915
Jefferson City, MO 65102
573/751-2270

Region 7
Division of Aging
Wainwright Bldg., Room 500
111 N. 7th St.
St. Louis, MO 63101
314/340-7360

Missouri Division of Aging
Ombudsman Program Service Regions

Region 1a
Council of Churches of the Ozarks
627 N. Glenstone
P.O. Box 3947 G.S.
Springfield, MO 65808
417/862-3598

Region 1b
Eastern SMOA
RR6, Box 6794
Ava, MO 65608
417/683-3790

Region 2
Southeast MO Area Agency on Aging
1219 N. Kingshighway, Suite 100
Cape Girardeau, MO 63701
573/335-3331 or
800/392-8771

Region 3
District III Area Agency on Aging
106 W. Young Street
P.O. Box 1078
Warrensburg, MO 64093
660/747-3107

Region 4
Northwest MO Area Agency on Aging
106 South Smith
P.O. Box 265
Maysville, MO 64469
660/726-3800

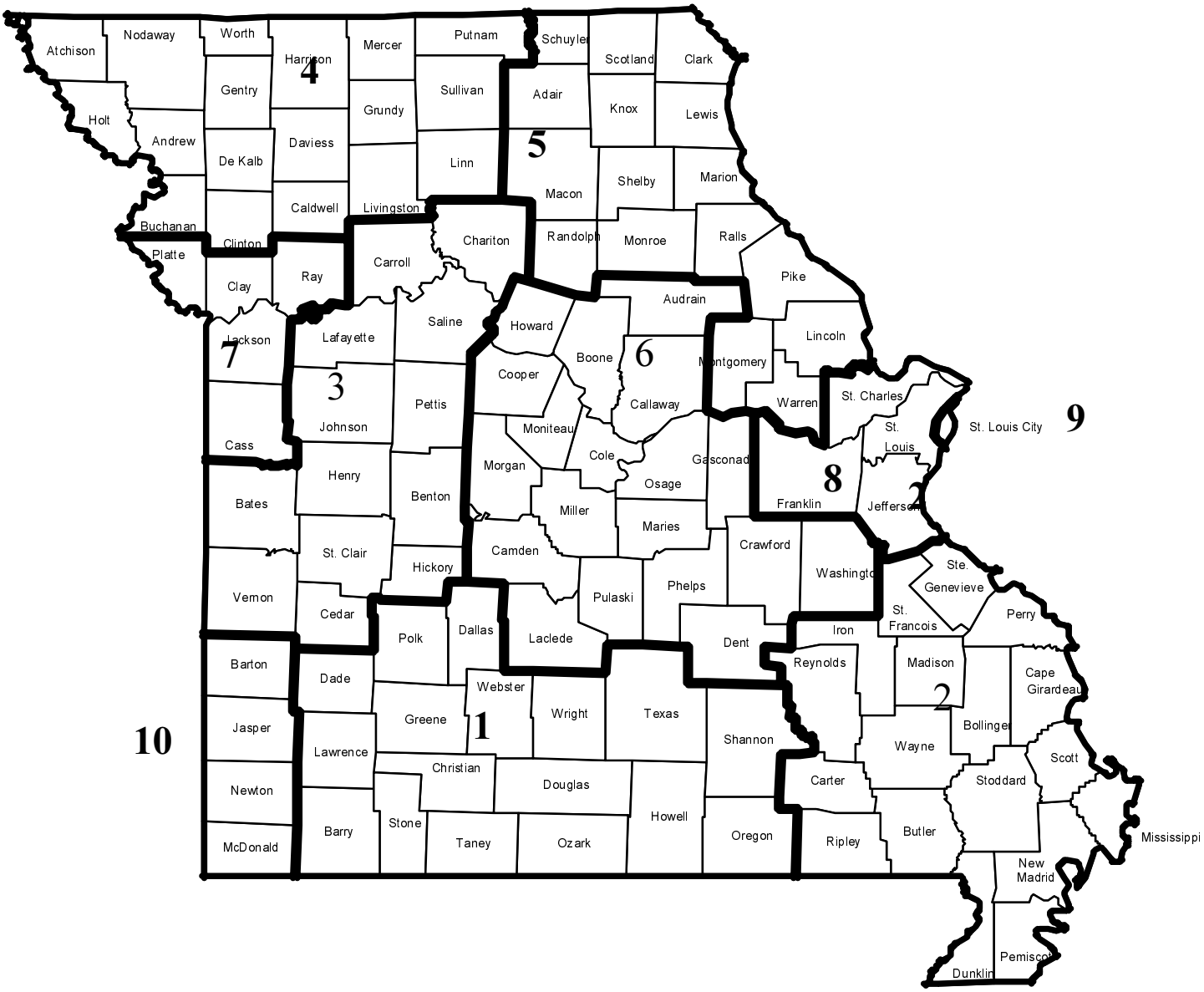
Region 5
MTLS Ombudsman Program
314 N. 11th Street
P.O. Box 248
Canton, MO 63435
573/288-5643

Region 6
Central MO Area Agency on Aging
1121 Business Loop 70 East
Suite 2A
Columbia, MO 65201
573/443-5823

Region 7
Mid-America Regional Council
300 Rivergate Center
600 Broadway
Kansas City, MO 64105-1536
816/474-4240

Regions 8 & 9
LTC Ombudsman Program
3028 N. Lindbergh
St. Ann, MO 63074-3244
314/298-9222

Region 10
Region X Area Agency on Aging
1710 E. 32nd St., Suite F
P.O. Box 3990
Joplin, MO 64803
417/781-7562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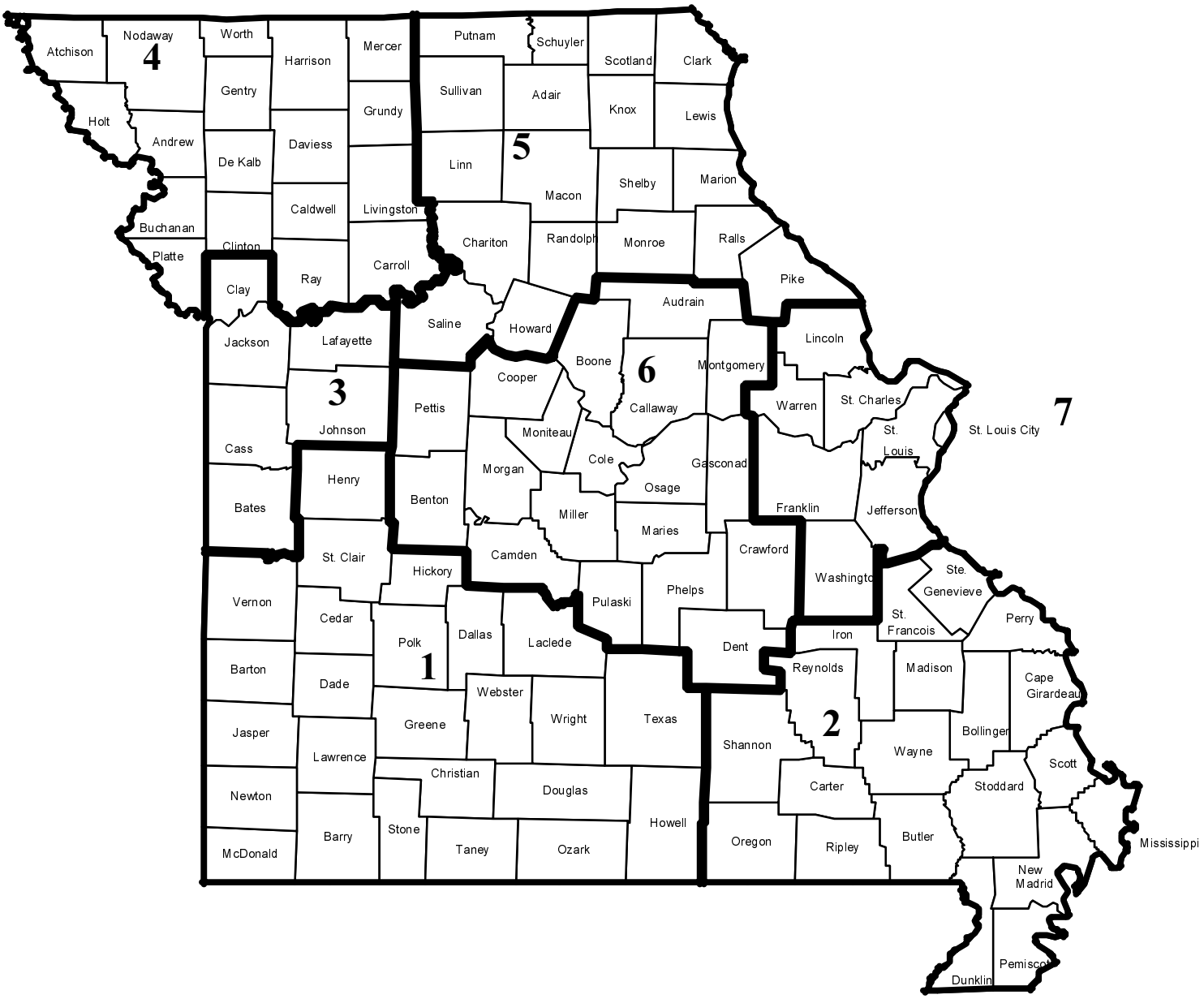
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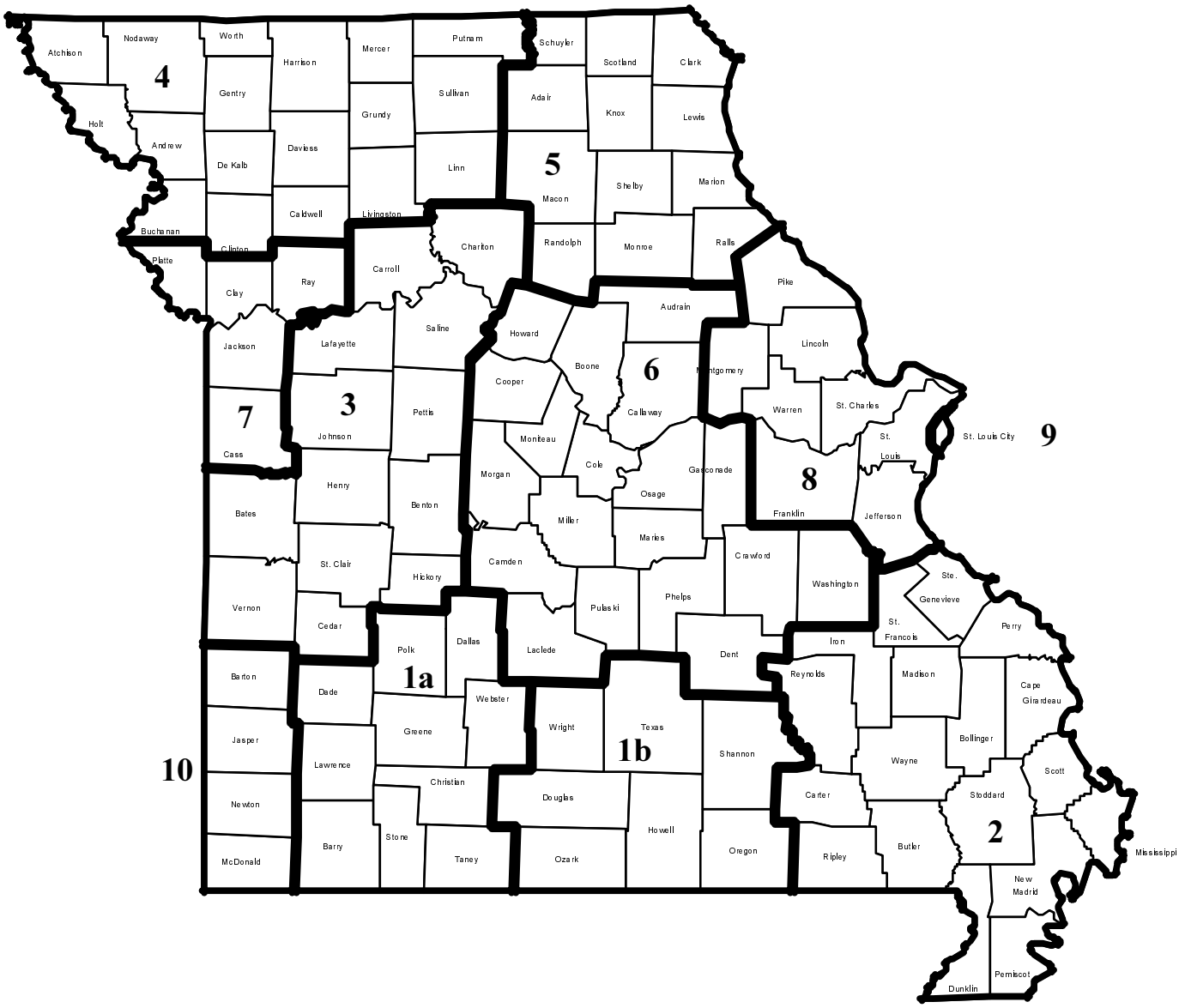
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Taney
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New Madrid
Pemiscot
Dunklin

		Disabled Adults Ages 18-59	Older Adults Ages 60+	Total
Region 1	Barry	10	58	68
	Christian	14	80	94
	Dade	2	12	14
	Dallas	7	36	43
	Douglas	8	37	45
	Greene	101	348	449
	Howell	19	63	82
	Lawrence	14	71	85
	Oregon	9	26	35
	Ozark	8	26	34
	Polk	11	24	35
	Shannon	7	12	19
	Stone	5	61	66
	Taney	22	82	104
	Texas	8	43	51
	Webster	9	25	34
	Wright	9	56	65
	Regional Total	**263**	**1,060**	**1,323**
Region 2	Bollinger	10	36	46
	Butler	67	156	223
	Cape Girardeau	30	105	135
	Carter	2	18	20
	Dunklin	38	95	133
	Iron	19	29	48
	Madison	15	41	56
	Mississippi	17	68	85
	New Madrid	42	77	119
	Pemiscot	27	91	118
	Perry	13	35	48
	Reynolds	7	21	28
	Ripley	13	53	66
	St. Francois	74	198	272
	Ste Genevieve	16	26	42
	Scott	32	152	184
	Stoddard	14	65	79
	Wayne	11	57	68
	Regional Total	**447**	**1,323**	**1,770**
Region 3	Bates	5	19	24
	Benton	6	31	37
	Carroll	3	17	20
	Cedar	5	7	12
	Chariton	8	12	20
	Henry	6	35	41
	Hickory	6	12	18
	Johnson	10	26	36
	Lafayette	11	52	63
	Pettis	20	94	114
	St Clair	6	15	21
	Saline	11	36	47
	Vernon	6	38	44
	Regional Total	**103**	**394**	**497**
Region 4	Andrew	5	26	31
	Atchison	5	25	30
	Buchanan	63	261	324
	Caldwell	5	23	28
	Clinton	3	18	21
	Daviess	3	20	23
	DeKalb	2	18	20
	Gentry	11	9	20
	Grundy	3	26	29
	Harrison	8	20	28
	Holt	0	9	9
	Linn	3	34	37

		Disabled Adults Ages 18-59	Older Adults Ages 60+	Total
	Livingston	5	18	23
	Mercer	3	11	14
	Nodaway	10	25	35
	Putnam	2	9	11
	Sullivan	2	22	24
	Worth	3	2	5
	Regional Total	**136**	**576**	**712**
Region 5	Adair	19	71	90
	Clark	5	29	34
	Knox	4	38	42
	Lewis	5	18	23
	Lincoln	20	51	71
	Macon	8	46	54
	Marion	8	50	58
	Monroe	0	20	20
	Montgomery	6	29	35
	Pike	16	67	83
	Ralls	0	11	11
	Randolph	22	93	115
	Schulyler	3	20	23
	Scotland	1	24	25
	Shelby	5	16	21
	Warren	3	20	23
	Regional Total	**125**	**603**	**728**
Region 6	Audrain	17	39	56
	Boone	77	154	231
	Callaway	12	52	64
	Camden	11	53	64
	Cole	34	126	160
	Cooper	1	25	26
	Crawford	21	48	69
	Dent	8	32	40
	Gasconade	4	25	29
	Howard	7	21	28
	Laclede	17	56	73
	Maries	4	25	29
	Miller	15	58	73
	Moniteau	2	27	29
	Morgan	12	39	51
	Osage	8	23	31
	Phelps	49	109	158
	Pulaski	30	104	134
	Washington	17	42	59
	Regional Total	**346**	**1,058**	**1,404**
Region 7	Cass	27	77	104
	Clay	38	155	193
	Jackson	412	1,733	2,145
	Platte	7	40	47
	Ray	10	34	44
	Regional Total	**494**	**2,039**	**2,533**
Region 8	Franklin	37	154	191
	Jefferson	66	266	332
	St Charles	60	219	279
	St Louis County	326	1,594	1,920
	Regional Total	**489**	**2,233**	**2,722**
Region 9	St Louis City	387	1,597	1,984
	Regional Total	**387**	**1,597**	**1,984**
Region 10	Barton	3	17	20
	Jasper	77	228	305
	McDonald	6	23	29
	Newton	15	57	72
	Regional Total	**101**	**325**	**426**
	State Total	**2,891**	**11,208**	**14,099**

		Reason to Believe	Suspected	Unsubstantiated	Total
Region 1	Barry	31	15	10	56
	Christian	39	25	21	85
	Dade	12	0	0	12
	Dallas	29	5	6	40
	Douglas	21	18	6	45
	Greene	236	67	106	409
	Howell	41	8	17	66
	Lawrence	38	11	22	71
	Oregon	19	1	7	27
	Ozark	20	4	5	29
	Polk	18	10	8	36
	Shannon	6	3	7	16
	Stone	25	26	14	65
	Taney	58	17	15	90
	Texas	29	7	7	43
	Webster	15	7	7	29
	Wright	26	12	21	59
	Regional Total	**663**	**236**	**279**	**1,178**
Region 2	Bollinger	30	1	3	34
	Butler	128	17	58	203
	Cape Girardeau	59	16	28	103
	Carter	14	0	5	19
	Dunklin	76	16	33	125
	Iron	26	9	12	47
	Madison	44	5	5	54
	Mississippi	55	10	6	71
	New Madrid	67	27	19	113
	Pemiscot	74	17	18	109
	Perry	18	10	10	38
	Reynolds	13	7	8	28
	Ripley	46	7	10	63
	St Francois	144	67	40	251
	Ste Genevieve	26	5	6	37
	Scott	94	24	49	167
	Stoddard	50	10	19	79
	Wayne	53	0	7	60
	Regional Total	**1,017**	**248**	**336**	**1,601**
Region 3	Bates	13	8	5	26
	Benton	28	9	6	43
	Carroll	13	3	5	21
	Cedar	15	4	0	19
	Chariton	13	4	2	19
	Henry	31	9	5	45
	Hickory	9	4	2	15
	Johnson	19	4	10	33
	Lafayette	30	12	9	51
	Pettis	86	4	17	107
	St Clair	8	8	4	20
	Saline	30	6	4	40
	Vernon	11	10	20	41
	Regional Total	**306**	**85**	**89**	**480**
Region 4	Andrew	11	10	9	30
	Atchison	15	2	4	21
	Buchanan	145	79	76	300
	Caldwell	22	1	6	29
	Clinton	11	3	3	17
	Daviess	13	1	6	20
	DeKalb	11	9	3	23
	Gentry	13	3	2	18
	Grundy	8	6	14	28
	Harrison	17	2	1	20
	Holt	1	6	3	10
	Linn	8	11	12	31

		Reason to Believe	Suspected	Unsubstantiated	Total
	Livingston	14	2	2	18
	Mercer	11	1	4	16
	Nodaway	24	3	2	29
	Putnam	10	1	0	11
	Sullivan	15	6	4	25
	Worth	2	0	2	4
	Regional Total	**351**	**146**	**153**	**650**
Region 5	Adair	44	20	21	85
	Clark	27	5	4	36
	Knox	35	4	6	45
	Lewis	18	3	3	24
	Lincoln	50	6	8	64
	Macon	40	6	8	54
	Marion	42	5	4	51
	Monroe	12	9	5	26
	Montgomery	11	4	12	27
	Pike	50	8	14	72
	Ralls	5	3	2	10
	Randolph	90	9	21	120
	Schuyler	12	3	2	17
	Scotland	18	7	5	30
	Shelby	13	6	3	22
	Warren	17	2	2	21
	Regional Total	**484**	**100**	**120**	**704**
Region 6	Audrain	24	8	13	45
	Boone	121	29	42	192
	Callaway	50	3	16	69
	Camden	32	5	17	54
	Cole	89	23	27	139
	Cooper	11	3	6	20
	Crawford	31	9	16	56
	Dent	28	6	12	46
	Gasconade	20	1	3	24
	Howard	9	5	3	17
	Laclede	51	15	11	77
	Maries	7	6	12	25
	Miller	17	50	4	71
	Moniteau	18	1	6	25
	Morgan	34	5	7	46
	Osage	17	1	11	29
	Phelps	84	26	21	131
	Pulaski	76	4	22	102
	Washington	24	9	24	57
	Regional Total	**743**	**209**	**273**	**1,225**
Region 7	Cass	56	18	5	79
	Clay	81	51	39	171
	Jackson	986	496	566	2,048
	Platte	40	3	4	47
	Ray	26	14	4	44
	Regional Total	**1,189**	**582**	**618**	**2,389**
Region 8	Franklin	84	22	42	148
	Jefferson	169	46	50	265
	St Charles	110	37	50	197
	St Louis County	780	444	390	1,614
	Regional Total	**1,143**	**549**	**532**	**2,224**
Region 9	St Louis City	833	405	433	1,671
	Regional Total	**833**	**405**	**433**	**1,671**
Region 10	Barton	9	1	8	18
	Jasper	64	109	75	248
	McDonald	12	8	2	22
	Newton	35	9	13	57
	Regional Total	**120**	**127**	**98**	**345**
	State Total	**6,849**	**2,687**	**2,931**	**12,467**

Appendix f.
Initial Reports of Institutional Abuse, Neglect and Regulation Violations
By County and Service Region for FY 1999

		Abuse, Neglect	Regulation Violations	Total
Region 1	Barry	2	13	15
	Barton	0	8	8
	Cedar	1	11	12
	Christian	12	27	39
	Dade	1	6	7
	Dallas	0	9	9
	Douglas	0	16	16
	Greene	28	290	318
	Henry	5	17	22
	Hickory	0	2	2
	Howell	4	42	46
	Jasper	20	130	150
	Laclede	3	42	45
	Lawrence	4	31	35
	McDonald	1	17	18
	Newton	3	116	119
	Ozark	0	3	3
	Polk	7	25	32
	St Clair	3	3	6
	Stone	1	16	17
	Taney	2	27	29
	Texas	1	7	8
	Vernon	5	35	40
	Webster	2	26	28
	Wright	0	15	15
	Regional Total	**105**	**934**	**1,039**
Region 2	Bollinger	0	24	24
	Butler	3	51	54
	Cape Girardeau	7	70	77
	Carter	1	1	2
	Dunklin	4	40	44
	Iron	0	16	16
	Madison	0	15	15
	Mississippi	0	7	7
	New Madrid	3	22	25
	Oregon	0	9	9
	Pemiscott	0	9	9
	Perry	2	32	34
	Reynolds	0	6	6
	Ripley	0	12	12
	St Francois	7	88	95
	Ste Genevieve	2	16	18
	Scott	3	37	40
	Shannon	0	4	4
	Stoddard	4	28	32
	Wayne	0	10	10
	Regional Total	**36**	**497**	**533**
Region 3	Bates	1	9	10
	Cass	11	52	63
	Clay	15	142	157
	Jackson	105	693	798
	Johnson	4	23	27
	Lafayette	2	25	27
	Regional Total	**138**	**944**	**1,082**
Region 4	Andrew	2	23	25
	Atchison	0	6	6
	Buchanan	9	71	80
	Caldwell	3	21	24
	Carroll	1	11	12
	Clinton	2	21	23
	Daviess	2	17	19
	DeKalb	3	35	38

		Abuse, Neglect	Regulation Violations	Total
	Gentry	0	16	16
	Grundy	1	9	10
	Harrison	0	5	5
	Holt	0	6	6
	Livingston	1	10	11
	Mercer	0	4	4
	Nodaway	2	15	17
	Platte	4	75	79
	Ray	1	16	17
	Worth	1	2	3
	Regional Total	**32**	**363**	**395**
Region 5	Adair	3	23	26
	Chariton	2	26	28
	Clark	0	2	2
	Howard	0	15	15
	Knox	5	20	25
	Lewis	2	5	7
	Linn	1	13	14
	Macon	1	13	14
	Marion	11	63	74
	Monroe	4	10	14
	Pike	2	11	13
	Putnam	1	2	3
	Ralls	1	11	12
	Randolph	3	46	49
	Saline	4	29	33
	Schuyler	0	1	1
	Scotland	1	10	11
	Shelby	0	5	5
	Sullivan	0	9	9
	Regional Total	**41**	**314**	**355**
Region 6	Audrain	2	19	21
	Benton	2	17	19
	Boone	7	131	138
	Callaway	6	47	53
	Camden	1	22	23
	Cole	10	117	127
	Cooper	6	22	28
	Crawford	2	62	64
	Dent	1	14	15
	Gasconade	0	6	6
	Maries	0	4	4
	Miller	4	27	31
	Moniteau	1	19	20
	Montgomery	0	26	26
	Morgan	1	24	25
	Osage	6	18	24
	Pettis	2	49	51
	Phelps	4	38	42
	Pulaski	2	34	36
	Regional Total	**57**	**696**	**753**
Region 7	Franklin	2	53	55
	Jefferson	16	242	258
	Lincoln	4	45	49
	St Charles	7	90	97
	St Louis County	136	1,176	1,312
	Warren	2	13	15
	Washington	0	22	22
	St Louis City	41	409	450
	Regional Total	**208**	**2,050**	**2,258**
	State Total	**617**	**5,798**	**6,415**

		Valid	Invalid, Not in Violation	Unable to Verify	Total
Region 1	Barry	3	8	4	15
	Barton	1	6	1	8
	Cedar	2	7	3	12
	Christian	11	17	11	39
	Dade	4	2	1	7
	Dallas	3	5	1	9
	Douglas	6	8	2	16
	Greene	74	163	81	318
	Henry	8	9	5	22
	Hickory	0	2	0	2
	Howell	19	20	7	46
	Jasper	40	70	40	150
	Laclede	13	24	8	45
	Lawrence	11	11	13	35
	McDonald	8	8	2	18
	Newton	45	50	24	119
	Ozark	0	2	1	3
	Polk	14	16	2	32
	St Clair	3	2	1	6
	Stone	7	8	2	17
	Taney	7	14	8	29
	Texas	2	4	2	8
	Vernon	11	16	12	39
	Webster	7	15	6	28
	Wright	3	11	1	15
	Regional Total	**302**	**498**	**238**	**1,038**
Region 2	Bollinger	13	11	0	24
	Butler	11	41	2	54
	Cape Girardeau	14	60	3	77
	Carter	0	2	0	2
	Dunklin	7	32	5	44
	Iron	4	12	0	16
	Madison	3	12	0	15
	Mississippi	1	6	0	7
	New Madrid	3	20	2	25
	Oregon	0	9	0	9
	Pemiscott	1	8	0	9
	Perry	8	24	2	34
	Reynolds	0	6	0	6
	Ripley	1	10	1	12
	St Francois	14	75	6	95
	Ste Genevieve	6	11	1	18
	Scott	5	35	0	40
	Shannon	2	2	0	4
	Stoddard	7	25	0	32
	Wayne	1	9	0	10
	Regional Total	**101**	**410**	**22**	**533**
Region 3	Bates	1	7	2	10
	Cass	13	34	16	63
	Clay	25	102	30	157
	Jackson	98	562	137	797
	Johnson	3	19	5	27
	Lafayette	2	20	5	27
	Regional Total	**142**	**744**	**195**	**1,081**
Region 4	Andrew	7	16	2	25
	Atchison	2	4	0	6
	Buchanan	28	41	11	80
	Caldwell	13	10	1	24
	Carroll	4	7	1	12
	Clinton	9	12	2	23
	Daviess	2	12	5	19
	DeKalb	14	19	5	38

		Valid	Invalid, Not in Violation	Unable to Verify	Total
	Gentry	7	8	1	16
	Grundy	5	4	1	10
	Harrison	0	5	0	5
	Holt	1	5	0	6
	Livingston	3	7	1	11
	Mercer	1	3	0	4
	Nodaway	1	12	4	17
	Platte	35	33	11	79
	Ray	8	6	3	17
	Worth	2	1	0	3
	Regional Total	**142**	**205**	**48**	**395**
Region 5	Adair	12	10	4	26
	Chariton	14	11	3	28
	Clark	1	1	0	2
	Howard	4	10	1	15
	Knox	16	6	3	25
	Lewis	4	2	1	7
	Linn	1	9	4	14
	Macon	4	9	1	14
	Marion	36	30	8	74
	Monroe	4	5	5	14
	Pike	3	9	1	13
	Putnam	2	1	0	3
	Ralls	3	8	1	12
	Randolph	17	28	4	49
	Saline	7	21	5	33
	Schuyler	1	0	0	1
	Scotland	6	3	2	11
	Shelby	2	2	0	4
	Sullivan	3	6	0	9
	Regional Total	**140**	**171**	**43**	**354**
Region 6	Audrain	2	16	3	21
	Benton	4	13	2	19
	Boone	45	58	35	138
	Callaway	11	35	7	53
	Camden	5	15	3	23
	Cole	39	59	29	127
	Cooper	9	13	6	28
	Crawford	25	31	8	64
	Dent	2	10	3	15
	Gasconade	0	6	0	6
	Maries	3	1	0	4
	Miller	6	23	2	31
	Moniteau	3	14	3	20
	Montgomery	10	14	2	26
	Morgan	4	19	2	25
	Osage	8	13	3	24
	Pettis	8	31	12	51
	Phelps	8	31	3	42
	Pulaski	6	25	5	36
	Regional Total	**198**	**427**	**128**	**753**
Region 7	Franklin	15	24	16	55
	Jefferson	74	121	63	258
	Lincoln	23	14	12	49
	St Charles	34	42	21	97
	St Louis County	359	515	434	1,308
	Warren	1	8	6	15
	Washington	14	6	2	22
	St Louis City	148	190	111	449
	Regional Total	**668**	**920**	**665**	**2,253**
	State Total	**1,693**	**3,375**	**1,339**	**6,407**

Professionals mandated to report in accordance with:	660.300	565.188	198.070
Adult Day Care Center Workers		yes	yes
Chiropractors	yes	yes	yes
Christian Science Practitioners	yes	yes	yes
Clinic personnel engaged in treatment, examination, care; adults 60+		yes	
Clinic personnel engaged in the examination of person age 60+			yes
Coroner		yes	yes
Dentist	yes	yes	yes
Department of Health Employee	yes		
Department of Mental Health Employee	yes		yes
Department of Social Services Employee	yes		yes
Facility Administrator			yes
Facility Employee (also see Nursing Home Worker)			yes
Health practitioners engaged in treatment, examination, care; persons age 60+		yes	
Hospital personnel engaged in treatment, examination, care; adults age 60+		yes	
In-Home Services employees, operators and owners	yes		
Interns (also see Resident Intern)			yes
Law Enforcement Officials (also see Peace Officers)		yes	yes
Medical Examiner	yes	yes	yes
Mental Health Professionals		yes	yes
Ministers	yes		yes
Nurse (also see Registered Nurse)	yes	yes	yes
Nursing Home Worker (also see facility employee)		yes	
Optometrist	yes	yes	yes
Other Health Practitioner			yes
Other person with responsibility for the care of persons 60+		yes	
Other person with responsibility for the care of an eligible adult			yes
Peace Officer	yes	yes	yes
Pharmacist	yes		yes
Physical Therapist	yes		yes
Physician	yes	yes	yes
Podiatrist	yes	yes	yes
Probation or Parole Officer		yes	yes
Psychologist	yes	yes	yes
Registered Nurse (also see Nurse)	yes	yes	
Resident Intern	yes	yes	
Social Worker	yes	yes	yes

* 660.300 Abuse/Neglect of in-home services clients 198.070 Resident of a nursing facility has been abused or neglected
565.188 Person (age 60 or older) has been subjected to conditions which would reasonably result in abuse or neglect